No. 03-3459

In the United States Court of Appeals for the Eighth Circuit

SHARON HATCHER
Plaintiff/Appellant

V.

JO ANNE B. BARNHART, COMMISSIONER,
SOCIAL SECURITY ADMINISTRATION
Defendant/Appellee

ON APPEAL FROM THE
UNTIED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
JONESBORO DIVISION

BRIEF OF APPELLANT

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SUMMARY OF THE CASE AND REQUEST FOR ORAL ARGUMENT

This is an appeal by Sharon Hatcher from an Order of the United States District Court for the Eastern District of Arkansas, affirming the Commissioner's decision which denied Hatcher's application for disability insurance benefits (Title II). Hatcher filed an application for benefits in September 1998. Her claim was denied through all administrative levels. She sought review of the Commissioner's decision in the United States District Court for the Eastern District of Arkansas, arguing that it was not supported by substantial evidence. On September 8, 2003, the district court affirmed the Commissioner's decision. This appeal followed.

The appellant believes that oral argument would be of material assistance to the Court in deciding this case, and thus, respectfully requests that her attorney be given fifteen minutes in which to present oral argument.

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JURISDICTIONAL STATEMENT

(i) This appeal is from an order filed on September 8, 2003, in the United States District Court for the Eastern District of Arkansas, Jonesboro Division, No. 3:01CV00318-HDY, issued by the Honorable H. David Young, United States Magistrate Judge.

(ii) The United States District Court for the Eastern District of Arkansas had proper jurisdiction to review a final decision of the Commissioner of the Social Security Administration pursuant to 42 U.S.C. § 405(g).

(iii) Pursuant to 28 U.S.C. § 1291, this Court has jurisdiction to review the final judgment of the United States District Court entered on September 8, 2003, from which the appellant filed a timely notice of appeal on September 29, 2003.

STATEMENT OF THE ISSUE

Whether the Commissioner's decision that Sharon Hatcher is not disabled within the meaning of the Social Security Act is supported by substantial evidence on the record as a whole.

Prince v. Bowen, 894 F.2d 283 (8th Cir. 1990)

Kelley v. Callahan, 133 F.3d 583 (8th Cir. 1998)

Cline v. Sullivan, 939 F.2d 560 (8th Cir. 1991)

STATEMENT OF THE CASE

Sharon Hatcher filed an application for disability insurance benefits on September 28, 1998. (Tr. 100-02). Her claim was denied at the initial and reconsideration levels (Tr. 84-90). A hearing was held on January 25, 2000, before an Administrative Law Judge (ALJ), which was attended by Hatcher, her attorney, and a vocational expert. (Tr. 44-79). On July 26, 2000, the ALJ issued an unfavorable decision denying Hatcher's claim. (AD 1-20; Tr. 17-36). On September 18, 2001, the Appeals Council denied Hatcher's request for review. (AD 21-22; Tr. 8-9). Hatcher sought judicial review of the Commissioner's denial. On September 8, 2003, the district court affirmed the Commissioner's decision. (AD 23-27). This appeal followed.

STATEMENT OF FACTS

A. Testimonial and documentary evidence.

Sharon Hatcher was born on March 22, 1953, and was forty-six years old at the time of the hearing. She has a tenth grade education and GED. (Tr. 47). She has past relevant work as a receptionist, office nurse, telemarketer, and office/church janitor. (Tr. 48).

Hatcher is disabled due to arthritis, fibromyalgia, chronic fatigue syndrome, bilateral carpal tunnel syndrome, and depression. Her fingers are often numb and swell. (Tr. 60). She wears wrist splints on both wrists, and only takes them off when she bathes. (Tr. 60). She also has difficulty staying focused and sometimes has problems comprehending things. (Tr. 64).

Hatcher testified that she could walk only half a block, stand for two to three minutes, and sit for five to six minutes. (Tr. 57). She cannot bend, stoop, or knee. (Tr. 62). She can carry a gallon of milk only if she braces it against her chest. (Tr. 59). She is unable to open sealed jars or to sew. (Tr. 60). She is no longer able to do her housework, and only takes a shower when her husband is home in case she falls. (Tr. 61). Her husband does the laundry, and loads and unloads the dishes. She goes with him sometimes when he does the shopping. (Tr. 62). Hobbies used to include horseback riding, swimming, riding a motorcycle, and boating. (Tr. 61-62). She has not been able to do any of these things since 1997. (Tr. 62). She is not involved in any churches, clubs, or organizations. She only drives to go to doctor appointments when her husband is at work. (Tr. 69).

During an average day, Hatcher spends about five hours in bed. Although she listens to the radio and watches television, she cannot stay focused long enough to read. (Tr. 63). She has difficulty sleeping and often has to get up to put on an ice pack. (Tr. 63).

At the time of the hearing, Hatcher was seeing her family physician, Dr. Williams, once or twice a month, Dr. Leaird for cortisone shots every six to nine weeks, her psychologist every week to two weeks, and a psychiatrist for medication maintenance for two to four months. (Tr. 53-54). Each of her doctors is aware of all the medications she is taking. (Tr. 66). Despite her numerous medications, Hatcher continues to suffer from pain. (Tr. 55). Side-effects include dry mouth, fuzzy thinking, grogginess, stomach problems, and diarrhea. (Tr. 64).

Hatcher attended a fibromyalgia workshop a couple of times, but reaching the classroom involved going up and down stairs. She has also undergone physical therapy, and uses heat, cold packs, and rubs. (Tr. 56). She has three different types of back braces, and knee braces. (Tr. 58).

Dennis Hatcher, the claimant's husband, testified that he has seen his wife's knee caps swell to the point that they looked like they were going to pop. He stated that his wife would be working if she could. (Tr. 70-72).

Beth Clem, a vocational expert, also testified at the hearing. In the first hypothetical question, the ALJ asked the VE to assume an individual who is forty-six years old with a tenth grade education and GED. She can lift no more than one pound; can occasionally stand for one hour our of an eight hour work period, two

to three minutes without interruption; sit for a total of two hours out of an eight hour work period, five to six minutes without interruption; and must spend four to five hours a day in bed. She can never climb, balance, stoop, crouch, kneel, or crawl. She is moderately limited in her ability to reach and handle, and severely limited in her ability to push/pull. She cannot work around moving machinery or vibration. She has a *good* ability to follow work rules, relate to coworkers, deal with the public, interact with supervisors, function independently, and understand, remember and carry out simple job instructions; and only *fair* ability to use judgment, deal with stress, maintain attention and concentration, understand, remember and carry out complex job instructions, maintain personal appearance, behave in an emotionally stable manner, relate predictably in social situations, and demonstrate reliability. (Tr. 74-75). The VE responded that such an individual could not return to her past relevant work due to the sitting and standing limitations, and could not perform any other jobs due to the need to lay down for four to five hours a day. (Tr. 75).

In a second hypothetical question, the ALJ asks the VE to assume an individual the same age, education, and past work experience as the claimant, who can lift and carry up to ten pounds occasionally; stand for a total of four hours in a work period, one hour without interruption; can sit for a total of six hours in an eight hour work day, two hours without interruption. The individual can never climb or crawl, but can occasionally balance, stoop, crouch, and knee. She has a slight impairment in the ability to reach and handle, and in the ability to push/pull. She

also is unable to work in areas of temperature extremes. The remainder is the same as hypothetical #1. The VE responded that such an individual could return to her past relevant work as a telemarketer. Other jobs such an individual could perform include that of phone operator and cashier. (Tr. 76).

B. Medical evidence.

Medical records reveal that from July 11, 1995, through April 29, 1998, Hatcher received treatment from Albert Fonticiella, M.D., on several occasion for chronic back pain, knee pain, and depression. Dr. Fonticiella prescribed Fiorinal (Tr. 219), Effexor (Tr. 220), Xanax (Tr. 212), and Naprosyn. (Tr. 218). Due to a three year history of back and left hip pain, a lumbar CT scan was performed on January 16, 1997. It revealed that Hatcher's bones are osteopenic, which is "somewhat unusual for the patient's age." (Tr. 215). Annular broad-based, disc bulges were observed at L3-L4 and L4-L5, along with a disc bulge at L5-S1. (Tr. 214). X-rays of the left knee revealed degenerative changes of the knee joint. (Tr. 204). At Hatcher's last visit on April 29, 1998, Dr. Fonticiella noted that James Schrantz, M.D., had aspirated 25 cc's of blood from Hatcher's left knee. Dr. Fonticiella explained to Hatcher that "she has got quite a bit of degenerative joint disease secondary to her lifestyle, work, etc." (Tr. 203). Hatcher stated that she understood this, but could not quit work because she had to make a living. (Tr. 203).

On May 6, 1998, Hatcher was treated by Claiborne Moseley, M.D., for left knee problems. Hatcher indicated that she had to push up with her hands to get up

from a chair or the commode. Dr. Moseley believed that Hatcher most likely had a partial quadriceps tear for which he recommended physical therapy. (Tr. 310).

X-rays of the left knee taken on May 7, 1998, revealed prominent focal lesions in the patellar cartilage consistent with high grade chondromalacia patella with some underlying bony changes, extensive abnormal signal intensity in the medial meniscus, and prominent joint effusion. (Tr. 191-92). A May 15, 1998 bone scan revealed findings consistent with severe chondromalacia of the patella, findings consistent with a pulling type injury from the patellar tendon insertion into the tibia and involving the lateral right humerus. (Tr. 189-90). Dr. Schrantz again aspirated and injected the knee on May 21, 1998. (Tr. 193). Hatcher also underwent physical therapy. (Tr. 194).

On June 1, 1998, Dr. Moseley noted that Hatcher still was experiencing tenderness over the left knee and was to continue going to physical therapy. (Tr. 195). On June 9, 1998, Hatcher reported that while her left knee was doing better, her right knee was swollen over the vastus laterallis. Dr. Moseley recommended a referral to Kimberly Leaird, M.D., a rheumatologist. (Tr. 194). Hatcher's sedentary rate and ANA testing were normal. (Tr. 198-99).

On June 29, 1998, Hatcher's right knee was swollen. Dr. Moseley aspirated clear joint fluid with small flecks of white material. He then injected her knee for symptomatic relief. (Tr. 228). During an August 4, 1998 visit, Hatcher presented with pain all over, tenderness over the lumbar spine, and grinding and slight swelling of both knees. Dr. Moseley diagnosed multiple arthralgias and myalgias,

with occasional swelling in both knees due to chondromalacia in both knees. He injected the L3, L4 and L5 areas to help relieve the pain. Lab results were normal and Dr. Moseley wondered if Hatcher might be suffering from early multiple sclerosis. (Tr. 225).

On August 21, 1998, Hatcher saw Dr. Leaird, a rheumatologist, for chronic aching of both knees, diffuse muscle achiness, increased fatigue, poor sleep, mild depressive symptoms, weight gain, and increased stress. Her current medications included Naprosyn, Xanax, Vicodin, and B12 shots monthly. (Tr. 229-31). Physical examination revealed a flattened affect, mild trapezius spasm, early osteoarthritic changes of the hands, mild crepitance in the knees, multiple classical trigger points, and tenderness over the trochanteric and anserine bursas. Dr. Leaird diagnosed chondromalacie patella for which she recommended quadriceps strengthening exercises, water therapy, and continued Naprosyn. She also diagnosed fibromyalgia, for which she prescribed Pamelor for sleep and injected two very tender paralumbar trigger points. Dr. Leaird also believed that Hatcher was suffering from an underlying mood disorder which was likely contributing to her pain complaints, and prescribed Paxil. She further diagnosed bursitis and injected each anserine bursa and each trochanteric bursa. (Tr. 229-31).

On October 6, 1998, Dr. Leaird noted that while Hatcher's mood had improved, she was still waking up two to three times a night, was experiencing agoraphobia and anxiety, and was continuing to suffer from knee pain and additional fibromyalgic complaints. Physical examination was essentially

unchanged. Dr. Leaird administered trigger point and bursa injections. She increased the dosage of Pamelor, recommended she continue taking Paxil, and made a referral to a psychologist. (Tr. 144-45).

During a November 17, 1998 visit, Dr. Leaird noted that Hatcher's fibromyalgia had improved, and that she was doing well on Naprosyn, Pamelor, and Paxil. She administered trigger point and bursa injections, and continued to diagnose fibromyalgia, bursitis, and anxiety/depression. (Tr. 248).

On November 18, 1998, Hatcher was seen by Herbert Price, III, M.D., F.A.P.A., a psychiatrist, for occasional panic attacks and a reluctance to get out of the house. He recommended that she continue taking the Pamelor and Paxil. (Tr. 249).

Hatcher returned to Dr. Leaird on December 14, 1998, with increased achiness and headaches, as well as depressed mood with increasing anxiety and panic attacks. Dr. Leaird discontinued the Naprosyn and prescribed Arthrotec in its place. She also gave Hatcher samples of Paxil and advised her to begin an aerobic exercise program. (Tr. 272). On December 31, 1998, Dr. Leaird treated Hatcher for continued complaints, noting that Hatcher had started exercising three times a week. Dr. Leaird administered trigger point and bursa injections, and continued the Arthrotec. (Tr. 278).

On December 28, 1998, Dr. Price increased Hatcher's dosage of Pamelor and continued the Paxil. On January 25, 1998, he noted that Hatcher was continuing to have sleeping problems. Although Hatcher continued to believe she was not depressed, she did acknowledge that she was suffering from social phobia. Dr.

Price increased the dosage of Paxil and Pamelor. During an office visit on February 22, 1999, Hatcher reported that her mood was improved, although she stated that she was having a "real hard time." Dr. Price continued her on Pamelor and Paxil. (Tr. 279).

On January 15, 1999, Dr. Williams prescribed bilateral wrist splints for carpal tunnel syndrome. (Tr. 418). On February 1, 1999, he treated Hatcher for carpal tunnel syndrome, swelling all over, and a severe headache. (Tr. 414-16).

On March 22, 1999, Dr. Price ordered Hatcher to continue taking Pamelor and Paxil. (Tr. 153).

On March 29, 1999, Hatcher was treated by Dr. Leaird for chronic pain associated with fibromyalgia. Nerve conduction studies showed evidence of mild carpal tunnel syndrome. Upon examination, Dr. Leaird observed that Hatcher had multiple classical trigger points and recurrent tenderness over the anserine and trochanteris bursas. Trigger point injections had been effective for four to five weeks in the past. Her ALT was minimally elevated. Dr. Leaird diagnosed fibromyalgia, bursitis, and carpal tunnel syndrome. She administered two paralumbar trigger point injections, injected each trochanteric bursa, and recommended that Hatcher wear her splints at night. (Tr. 159-60).

On April 7, 1999, Dr. Williams refilled Hatcher's medications for Vicodin, Xanax, Naprosyn, Nararel Spray, Lorcet Plus, and Quinine Sulfate. (Tr. 409).

On April 15, 1999, Dr. Moseley noted that Hatcher's feet were tender around the ankles and that there was soreness and grinding in the knees. He also noted

that she walked like a stiff old man. He diagnosed fibromyalgia with depressive problems and multiple joint aches and pains, and bilateral carpal tunnel syndrome. He advised Hatcher to continue taking the Arthrotec and to keep wearing the wrist splints. (Tr. 304).

Hatcher returned to Dr. Leaird on May 10, 1999, with continued diffuse body pain and worsening depression, with increased irritability and increased fatigue. Physical examination revealed a flat affect, multiple classical trigger points, mild trapezius spasm, and recurrent tenderness over the anserine and trochanteric bursas. Dr. Leaird diagnosed trapezius muscle spasm, recurrent bursitis, fibromyalgia, and depression. She administered trigger point and bursa injections, recommended physical therapy, and referred Hatcher to Suzanne Throesch, Ph.D., for counseling. (Tr. 161-62).

During a May 24, 1999 office visit, Dr. Price noted that Hatcher was continuing to obsessively wash her hands, was able to drive despite her fears of being out in public, and was still receiving counseling from Dr. Throesch. He increased her dosage of Paxil and continued the Pamelor. (Tr. 153).

During a July 12, 1999 office visit, Dr. Leaird again noted multiple trigger points and bilateral tenderness over the anserine and trochanteric bursas. She administered trigger point and bursa injections, and recommended continued use of the wrist splints. (Tr. 163). Hatcher returned on July 19, 1999, with a positive Phalen's sign. Dr. Leaird diagnosed bilateral carpal tunnel syndrome and injected each wrist. (Tr. 164).

On July 30, 1999, Dr. Moseley noted that Hatcher was having difficulty falling and controlling her lower extremities, and she was having paresthesia in both upper and lower extremities. Hatcher was walking with a slight foot drop and was a bit hyper-reflexic. Dr. Moseley diagnosed Hatcher as suffering from a degenerative demyelinating disease, such as ALS or multiple sclerosis. (Tr. 303).

On August 2, 1999, Hatcher was seen by Ron South, M.D., a neurologist, for possible degenerative diseases. After examination, Dr. South believed that Hatcher's presentation was very suggestive of psychosomatic etiology, however, he also believed that MS was a possibility. (Tr. 325). A CT scan was negative (Tr. 327), while an MRI revealed sinus disease, probable dental disease, and mild chronic ischemic gliosis. (Tr. 328). Dr. South informed Hatcher that her workup was negative for MS or ALS. (Tr. 324).

On August 23, 1999, Dr. Price continued the Pamelor and Xanax, and began tapering down the Paxil. (Tr. 154).

Hatcher returned to Dr. Leaird on September 13, 1999, with increasing pain complaints and increased depression with intermittent tearfulness. Physical examination was unchanged. Dr. Leaird administered trigger point and bursa injections. (Tr. 165). On October 11, 1999, Hatcher returned with complaints of recurrent, bilateral wrist pain, and a positive Phalen's sign. Dr. Leaird injected both wrists. (Tr. 166). During a November 8, 1999 visit to Dr. Leaird, Hatcher reported chronic musculoskeletal pain and knee pain. Dr. Leaird noted that although her affect was brighter, Hatcher continued to present with multiple trigger points,

recurrent tenderness over both anserine and trochanteris bursas, and trapezius spasm. She administered trigger point, trochanteric bursa, and anserine bursa injections. She diagnosed chondromalacia patella for which she prescribed Naprelan instead of Arthrotec. (Tr. 167).

During a November 15, 1999 office visit, Dr. Price noted that Hatcher had been placed on Celexa by Dr. Leaird due to decompensation, and that she had began panicking while sitting in the waiting room because another patient was talking to herself. Dr. Price continued the Pamelor and Celexa. (Tr. 154).

Hatcher received prescriptions for Vicodin and Amitriptyline from Dwight Williams, M.D., on November 22, 1999. On November 20, 1999, Dr. Williams have her a B12 injection, as well as a Depo-Estradial injection. (Tr. 284).

On December 20, 1999, Dr. Leaird treated Hatcher for chronic diffuse pain complaints. Physical examination revealed a very flat affect, multiple classical trigger points, mild trapezius spasm, and tenderness over the trochanteric and anserine bursas. Dr. Leaird administered trigger point and bursa injections, gave her a trial of Celebrex in place of Arthrotec, and increased the dosage of Celexa. (Tr. 340).

On January 3 and 7, 2000, Dr. Williams gave Hatcher injections for back pain and refilled her medications. (Tr. 368-73). On January 19, 2000, Dr. Williams noted trigger point tenderness along the spine, forearms, and neck, noting that her condition had deteriorated. Dr. Williams diagnosed severe fibromyalgia and refilled prescriptions for Amitriptyline, Quinine Sulfate, and Vicodin. He stated, “Pt

unable to work at present and for foreseeable 12 months, since [fibromyalgia] has bothered her several years and worsening." (Tr. 365-67).

In a January 10, 2000 letter, Barry Harris, O.D., stated that Hatcher suffers from vitreous floaters, dry eye syndrome, and low hyperopia with concurrent presbyopia. He indicated that he had given her a prescription for tear replacement therapy and a glasses prescription. (Tr. 314).

On January 12, 2000, Dr. Leaird injected Hatcher's wrists and an upper lumbar trigger point. (Tr. 339).

In a January 21, 2000 letter, Alan Crawford, D.D.S., stated that he began treating Hatcher for TMJ on February 2, 1998. Symptoms included pain in the area joint, massater, and temporalis, accompanied by trigger points. He fitted her with a bite splint, prescribed muscle relaxers, and counseled her on lifestyle changes. Hatcher's symptoms initially improved but flared up frequently. Dr. Crawford stated that he was continuing to treat Hatcher and that she would experience some TMJ symptoms with accompanying chronic discomfort for the rest of her life. (Tr. 313).

In a January 24, 2000 office note, Suzanne Throesch, Pys. D., noted that Hatcher had been undergoing weekly therapy since May 24, 1999 and had recently reduced her visits to every other week. An MMPI-2 profile strongly suggested that Hatcher responds to stress with physical exacerbation. Depressed mood, anxiety, and limited coping skills also complicated her physical health, as well as a history of panic disorder. Dr. Throesch stated:

> Initially progress in therapy was slow due to patient's strong resistance tendencies. Ms. Hatcher has difficulty adjusting her expectations of self to fit current physical limitations. In other words, she tends to think in ALL or NONE terms, expecting a complete healthy life experience or nothing, retreating to bed in avoidance. Adjustment issues are focus of therapy at this time. Ms. Hatcher has been cooperative and complaint with treatment recommendations. Progress has been demonstrated by patient's improved physical productivity level from poor to fair. (Tr. 315).

On February 8, 2000, Dr. Leaird treated Hatcher for increased body pain and no improvement in her mood. (Tr. 333). A CT scan performed on February 12, 2000, revealed a right para-central disc protrusion at L5, and a diffuse bulge at L4 disc with no neural foraminal or spinal canal compromise at any level. (Tr. 364). On February 23, 2000, Dr. Leaird administered paralumbar trigger point and bursa injections. (Tr. 332). Dr. Williams called in prescriptions for Lorcet Plus and Xanax. (Tr. 361).

On March 4, 2000, Hatcher was seen by Robert Valentine, M.D., with Arkansas Pain Centers. Physical examination revealed extremely limited lumbar range of motion, especially in flexion. There was tenderness over the lumbar spinous processes. A CT scan revealed a bulging disc at L5-S1. Dr. Valentine diagnosed fibromyalgia, chronic fatigue syndrome by history, low back pain from fibromyalgia, internal disc disruption, or possible facet syndrome, chondromalacia, and carpal tunnel syndrome. (Tr. 437-38).

On March 23, 2000, Dr. Williams noted that Hatcher's joints were tender and swollen. He gave her a Depo-Estradi injection, Cyanocobalam injection, and prescriptions for Lorcet Plus and Xanax. (Tr. 356-58). A March 24, 2000, chest x-

ray revealed degenerative changes of the lumbar spine with intervertebral spine, narrowing, and vacuum disc phenomena. An osteophyte was also seen over the adjacent thoracic vertebral bodies. (Tr. 354).

On March 27, 2000, Hatcher underwent a consultative general physical examination performed by Donald G. Leonard, M.D. Lumbar flexion was restricted to GR-s with so-called sway back as seen with hysteria. There were multiple classic trigger point areas of tenderness typical of fibromyalgia. Blood studies revealed a normal SED rate, negative serum rate, negative RA, and negative ANA. Dr. Leonard stated, "The lady has classic fibromyalgia. She does not appear to be physically or mentally impaired and probably would be able to hold down gainful employment." (Tr. 316-18). In a Medical Assessment of Ability to do Work-Related Activities (Physical), Dr. Leonard indicated that Hatcher could lift/carry up to fifty pounds occasionally and up to twenty pounds frequently, and could sit for eight hours, stand for eight hours, and walk for eight hours. Use of hands and feet were unaffected, but she could only occasionally kneel or crawl. (Tr. 319-23).

On April 3, 2000, Dr. Valentine noted that a CT scan revealed osteophyte formation in the lower thoracic spine along with a lumbar MRI revealing degenerative disease with disc bulge in the lower regions. She gave Hatcher a lumbar steroid injection. (Tr. 436). On April 17, 2000, Dr. Valentine noted that there was evidence of lumbar discogenic pain and possible facet arthropathy. He diagnosed lumbar discogenic pain/internal disc disruption, facet syndrome, and fibromyalgia, and administered another epidural steroid injection. (Tr. 478). Dr.

Valentine administered additional lumbar epidural injections on May 1, September 18, October 3, 2000 (Tr. 473-77).

On May 2, 2000, Dr. Leaird noted multiple classical trigger points, tenderness over the anserine and trochanteric bursas, and bilateral knee crepitance. Since Hatcher had undergone an epidural the day before, Dr. Leaird did not do additional trigger point injections, but did inject each anserine bursa. (Tr. 570). On May 22, 2000, Dr. Leaird treated Hatcher for recurrent low back and trochanteric pain. She administered two tender paralumbar trigger point injections, and injected each trochanteric bursa. She also advised that Hatcher continue the taking Arthrotec. (Tr. 569).

On July 24, 2000, Dr. Leaird noted about 1/2 cm of possible skin atrophy on the dorsal aspect of the right wrist, a positive Phalen's, multiple classical trigger points, and mild paralumbar spasm. She administered two paralumbar trigger point injections. (Tr. 529).

On October 9, 2000, Dr. Leaird injected the paralumbar trigger points, each trocanteric, each anserine bursa, and the left heel. (Tr. 528).

During an October 27, 2000 office visit, Dr. Valentine noted that Hatcher still was suffering from significant pain in her low back and radiating into the left hip and leg, despite the epidural injections. (Tr. 472).

On October 30, 2000, Dr. Leaird treated Hatcher for a plantar fascitis/heel spur with an injection. (Tr. 527).

On November 13, 2000, Dr. Valentine noted that a discogram revealed posterolateral tears at L4-L5 and L5-1 which caused intense concordant pain at rather low pressures. He diagnosed lumbar annular tear/internal disc disruption and felt Hatcher would be a good candidate for intradiscal electrothermal anuloplasty at both levels. (Tr. 468).

On December 5, 2000, Dr. Moseley treated Hatcher for a painful left foot. Examination revealed it was swollen on the dorsum with tenderness at the first, second, and third metatarsals. Normal range of motion was painful. X-rays did not reveal a break. Dr. Moseley diagnosed irritation and synovitis to the top of the left foot with possible stress reaction that has not shown up radiographically. (Tr. 514).

On February 28, 2001, Dr. Leaird treated Hatcher for chronic recurring back pain, noting multiple classical trigger points and some continuing paralumbar spasm. She gave her two paracervical and two paralumbar trigger point injections, noting that she was to continue taking Arthrotic and Celexa. (Tr. 505).

During an office visit on May 1, 2001, Dr. Williams treated Hatcher for myalgia with injections and a prescription for Lorcet Plus. (Tr. 443-44).

On May 8, 2001, Dr. Leaird treated Hatcher for marked increase in pain complaints. Physical examination revealed crepitance of the knees, multiple classical trigger points, and recurrent tenderness over the trochaneric and anserine bursas. Dr. Leaird diagnosed fibromyalgia/chronic pain disorder, recurrent bursitis, and patella chondromalacia. She injected two tender paralumbar trigger points and

each bursa, and continued the Celexa and Arthrotec. (Tr. 500). On May 22, 2001, Dr. Williams refilled prescriptions on Xanax and Lorcet Plus. (Tr. 490).

On June 11, 2001, Hatcher was treated by Dr. Williams for back pain. He refilled her medications for fibromyalgia pain and prescribed Pamelor. (Tr. 456). On June 12 and 21, 2001, Dr. Valentine gave Hatcher epidural steroid injections. (Tr. 464-66).

C. Administrative proceedings.

On July 26, 2000, the ALJ issued an unfavorable decision denying Hatcher's claim. (AD 1-20; Tr. 17-36). He evaluated Hatcher's application for benefits according to the familiar five-step analysis prescribed by the Social Security regulations, *see* 20 C.F.R. §§ 404.1520, 416.920, and found:

1. Hatcher was insured for benefits on September 15, 1997, the date she allegedly became disabled, and has not engaged in substantial gainful activity since then.

2. The medical evidence establishes that Hatcher suffers from a long history of severe musculoskeletal problems, mental problems, and pain.

3. Hatcher does not have any impairment(s) that meet or equal an impairment listed in Appendix 1.

4. Hatcher's subjective allegations are not entirely credible. She has the residual functional capacity to perform work-related activities except for work involving more than a narrowed range of sedentary work. Her past relevant work as a telemarketer did not require the performance of activities precluded by these

limitations. Because Hatcher can return to her past relevant work, she is not disabled under the Social Security Act. (AD 14-15; Tr. 30-31).

On September 18, 2001, the Appeals Council denied Hatcher's request for review. (AD 21-22; Tr. 8-9). Thus, the ALJ's decision stands as the final decision of the Commissioner and it is from this decision that Hatcher seeks judicial review.

SUMMARY OF THE ARGUMENT

The Commissioner's decision denying Sharon Hatcher's claim for disability insurance benefits is not supported by substantial evidence on the record as a whole. The ALJ improperly rejected the opinion of Hatcher's treating doctor that Forehand is disabled and wrongly discredited Forehand's testimony.

ARGUMENT

THE COMMISSIONER'S DECISION DENYING SHARON HATCHER'S CLAIM FOR DISABILITY INSURANCE BENEFITS IS NOT SUPPORTED BY SUBSTANTIAL EVIDENCE ON THE RECORD AS A WHOLE.

A. Standard of review.

Judicial review of the Commissioner's denial of benefits determines whether the Commissioner has correctly applied the law and whether there is substantial evidence on the record as a whole to support his decision. 42 U.S.C. § 405(g); *Keller v. Shalala*, 26 F.3d 856, 858 (8th Cir. 1994). Substantial evidence is not the same as any evidence; it is less than a preponderance, but enough that a reasonable mind might find adequate to support the Commissioner's conclusion. *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992). Moreover, "[t]he substantial evidence test employed in reviewing administrative findings is more than a mere search of the record for evidence supporting the [Commissioner's] findings." *Gavin v. Heckler*, 811 F.2d 1195, 1199 (8th Cir. 1987). The reviewing court must look for substantial evidence on the record as a whole, which requires the court to "take into account whatever in the record fairly detracts from its weight." *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951). Thus, the court must consider the weight of the evidence supporting the Commissioner's decision and how contradictory evidence detracts from that weight. *Gavin*, 811 F.2d at 1199 (noting that Universal Camera requires a "searching inquiry" into how any contradictory evidence balances out). *See Robinson*, 956 F.2d at 838 (emphasizing that the court must "do more than merely parse the record for substantial evidence supporting

the [Commissioner's] decision. [It] also must consider evidence in the record that detracts from the weight of the decision."); *Wilson v. Sullivan*, 886 F.2d 172, 176 (8th Cir. 1989) (reversing the district court's decision because the magistrate failed to take into account the weight of the evidence upon which the ALJ relied and to apply a balancing test to any contradicting evidence).

B. <u>The regulatory framework</u>.

The Commissioner has adopted regulations creating a five-step test to determine whether a claimant is disabled. *See* 20 C.F.R. § 404.1520(a)-(f); *Bowen v. Yuckert*, 482 U.S. 137, 140-42 (1987) (describing the process). The first two steps involve threshold determinations as to whether the claimant is not presently working and has an impairment which is of the required duration and which significantly limits her ability to work. 20 C.F.R. § 404.1520(a)-(c). In the third step, the medical evidence of the claimant's impairments is compared to a list of impairments presumed severe enough to preclude any gainful work. *See* 20 C.F.R. pt. 404, subpt. P, App. 1. If an impairment matches or is equal to one of the listed impairments, the claimant qualifies for benefits without further inquiry. *Id*. § 404.1520(d). If the claimant cannot qualify under the listings, the analysis proceeds to the fourth and fifth steps. At these steps, the inquiry is whether the claimant can do her own past work or any other work that exists in the national economy, in view of her age, education, and work experience. *Id*. § 404.1520(e)-(f). If a claimant demonstrates that she cannot perform her past work, the burden shifts to the Commissioner to show that there are other jobs in the national

economy the claimant can perform. If the claimant cannot do her past work or any other work, she qualifies for benefits.

C. The ALJ's residual functional capacity assessment is not supported by substantial evidence on the record as a whole.

Sharon Hatcher is unable to work due to severe fibromyalgia, chronic back pain with bulging discs and posterolateral tears at L4-5 and L5-S1, carpal tunnel syndrome, chronic knee pain from chondromalacia, TMJ with chronic discomfort, recurrent bursitis, depression, and chronic pain disorder. Her condition is consistent with one court's description of fibromyalgia as a "type of muscular or soft-tissue rheumatism that affects principally muscles and their attachment to bones, but which is also commonly accompanied by fatigue, sleep disturbances, lack of concentration, changes in mood or thinking, anxiety, and depression." *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech, Inc.,* 125 F.3d 794, 796 (9th Cir. 1997) (citing *Fibromyalgia,* Arthritis Foundation Pamphlet, at 1, 5 (1992)). The ALJ nevertheless found that Hatcher can perform a limited range of sedentary work and, therefore, can return to her past work as a telemarketer. This finding is not supported by substantial evidence on the record as a whole.

"Residual functional capacity" (RFC) describes what a claimant can do despite his limitations. 20 C.F.R. § 404.1545(a). Social Security Ruling 96-9p states that

> RFC is the individual's maximum remaining ability to perform sustained work on a regular and continuing basis; i.e., 8 hours a day, for 5 days a week, or an equivalent work schedule. It is not the least an individual can do, but the most, based on all of the information in the case record.

The Eighth Circuit has emphasized that residual functional capacity "is not the ability merely to lift weights occasionally in a doctor's office; rather, it is the ability to perform the requisite physical acts day in and day out, in the sometimes competitive and stressful conditions in which real people work in the real world." *McCoy v. Schweiker*, 683 F.2d 1138, 1147 (8th Cir. 1982) (en banc). The record shows that Hatcher does not possess the RFC to perform even a limited range of sedentary work on a sustained, continuing, "day in and day out" basis.

1. The ALJ improperly discounted the opinion of Dr. Williams, Hatcher's treating physician.

Dr. Williams has been treating Hatcher consistently since November 1997. (Tr. 241). In January 2000 Dr. Williams diagnosed Hatcher as suffering from "severe fibromyalgia" and stated that Hatcher is "unable to work at present and for foreseeable 12 months, since [fibromyalgia] has bothered her several years and worsening." (Tr. 367). It is well established that a treating physician's opinion should be accorded substantial weight and may be disregarded only if persuasive contradictory evidence exists. *See, e.g., Prince v. Bowen*, 894 F.2d 283, 285 (8th Cir. 1990). The ALJ acknowledged Dr. Williams' opinion, but rejected it because he believed (1) it was inconsistent with the clinical and laboratory findings in this case and (2) it was not a medical opinion but a vocational opinion and, thereby, invaded the province of the factfinder. (AD 5, 7; Tr. 21, 23). Neither of these "reasons" are supported by the record.

To begin with, the Commissioner's regulations specify that "[w]e will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion." 20 C.F.R. §§ 404.1527(d)(2). Social Security Ruling 96-5p provides that "[a]djudicators must weigh medical source statements under the rules set out in 20 C.F.R. §§ 404.1527 and 416.927, providing appropriate explanations for accepting or rejecting such opinions." The ruling goes on to say that treating source opinions, including opinions about issues reserved to the Commissioner, must be "carefully consider[ed]" and must be evaluated against all the evidence in the case "to determine the extent to which the opinion is supported by the record." Even if the ALJ ultimately rejects the opinion, SSR 96-5p specifies that "the notice of the determination or decision must explain the consideration given to the treating source's opinion(s)." The Second Circuit in *Snell v. Apfel,* 177 F.3d 128 (2d Cir. 1999), explains:

> Reserving the ultimate issue of disability to the Commissioner . . . does not exempt administrative decisionmakers from their obligation . . . to explain why a treating physician's opinions are not being credited. The requirement of reason-giving exists, in part, to let claimants understand the disposition of their cases, even--and perhaps especially—when those dispositions are unfavorable. A claimant like Snell, who knows that her physician has deemed her disabled, might be especially bewildered when told by an administrative bureaucracy that she is not, unless some reason for the agency's decision is supplied. *See* Jerry L. Mashaw, Due Process in the Administrative State 175-76 (1985). Snell . . . is entitled to be told why the Commissioner has decided—as under appropriate circumstances is his right—to disagree with Dr. Cooley. We therefore remand this case to the Appeals Council for a statement of the reasons on the basis of which Dr. Cooley's finding of disability was rejected.

Id. at 134. Similarly, this Court has emphasized that "whether the ALJ grants a treating physician's opinion substantial or little weight, the regulations also provide that the ALJ must always give good reasons for the particular weight given to a treating physician's evaluation." *Singh v. Apfel,* 222 F.3d 448 (8th Cir. 2000) (internal quotations omitted).

The only reason given by the ALJ for discounting Dr. Williams' opinion related to the record evidence is found in a single sentence in the ALJ's opinion: "The administrative law judge concludes that this opinion is not consistent with the clinical and laboratory findings in this case and accords it little weight." (AD-5; Tr. 21). But since the ALJ never identifies nor discusses the specific inconsistencies, this "reason" is nothing more than a conclusion. As such, it does not meet the "good reasons" requirement set forth by this Court and the Commissioner's own regulations.

The Commissioner's regulations specify that a treating doctor's opinion should be given *controlling* weight if it is supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record. 20 C.F.R. § 404.1527(d)(2). Even assuming *arguendo* that Dr. Williams' opinion is not well-supported by clinical and laboratory findings, the regulations never say that the treating doctor's opinion should be rejected for that reason alone. Social Security Ruling 96-2p explains:

> Adjudicators must remember that a finding that a treating source medical opinion is not well-supported by medically acceptable clinical and laboratory diagnostic techniques or is inconsistent with the other

> substantial evidence in the case record *means only that the opinion is not entitled to "controlling weight," not that the opinion should be rejected. Treating source medical opinions are still entitled to deference* and must be weighed using all of the factors provided in 20 CFR 404.1527 and 416.927. In many cases, a treating source's medical opinion will be entitled to the greatest weight and should be adopted, even if it does not meet the test for controlling weight.

SSR 96-2p, 1996 WL 374188, at *4 (Social Security Administration, July 2, 1996) (emphasis added). The factors listed in 20 C.F.R. § 404.1527(d)(2)-(6) include the length, frequency, nature, and extent of the treatment relationship, supportability by medical signs and laboratory findings, consistency with other evidence in the record as a whole, specialization, and familiarity with disability requirements.

The ALJ clearly ignored his legal obligation to assess Dr. Williams' opinion according to the factors set forth in section 404.1527. There is no discussion of these factors in his written opinion and how they weigh in favor or against giving significant weight to Dr. Williams' opinion. One important factor is the nature and length of the treating relationship:

> (d) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.
>
> . . . .
>
> (2) Treatment relationship. *Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations*. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-

> supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.
>
> (i) Length of the treatment relationship and the frequency of examination. *Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.*
>
> (ii) Nature and extent of the treatment relationship. *Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. . . .*

20 C.F.R. § 1527(d) (emphasis added).

When dealing with someone potentially disabled by fibromyalgia—a disease, as explained below, that is not readily detectable by standard medical tests—the length, nature, and extent of the treatment relationship take on added importance. For example, in differentiating fibromyalgia from other diseases, Dr. Lisa Sammaritano, associate professor of medicine at the Weill Medical College of Cornell University, explains that "[o]ne guide to the diagnosis of fibromyalgia is duration of symptoms; it is less likely to be another disorder if symptoms are present for many years." Lisa R. Sammaritano, M.D., *Fibromyalgia Syndrome* (Sept.

8, 2003).[1] Having treated Hatcher for several years, Dr. Williams was in the best position to determine the nature and severity of Hatcher's chronic pain and fatigue. This factor weighs heavily in favor of giving deference to Dr. Williams' opinion, and that is exactly what Hatcher's attorney pointed out to the ALJ in an April 2000 letter. The ALJ expressly rejected this factor in his written opinion:

> Claimant's attorney stated in a letter on April 24, 2000, that "It seems to me that the affects (sic) of fibromyalgia are better assessed over time, as some people who have the disease are mildly impacted, while other[s] are incapacitated by it. It would not be obvious to the one-time examiner which was which." (Exhibit 17E). *The undersigned disagrees.* The administrative law judge has carefully evaluated and weighed all the evidence in this case and is convinced that claimant is able to perform some work activity. (AD-8; Tr. 24) (emphasis added).[2]

The ALJ apparently succumbed to the temptation to "play doctor" and made his own independent medical findings. *See Delrosa v. Sullivan*, 922 F.2d 480, 484 (8th Cir. 1991) (holding that it is improper for an ALJ to substitute his "own unsubstantiated conclusions" regarding claimant's medical condition for that of physician); *Ness v. Sullivan*, 904 F.2d 432, 435 (8th Cir. 1990) (noting that the ALJ must not substitute his opinions for those of the physician).

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[1] Dr. Sammaritano's excellent article on fibromyalgia can be found online at *http://www.rheumatology.hss.edu/phys/diseaseReviews/fibroSynd/fibroSynd_phys.asp.* (Do not include the sentence period in the web address.).

[2] We note that the ALJ made conflicting statements regarding the weight to be given to Dr. Williams' opinion. He first concluded that Dr. Williams' opinion is entitled to "little weight" because it is not supported by the clinical and laboratory findings in the case. (AD-5; Tr. 21). He subsequently acknowledged that "great weight must be given to Dr. Dwight Williams' opinion by reason of his position as one of claimant's treating doctors," but then went on to find that Dr. Williams' opinion must be disregarded because it is not a medical opinion, but a vocational one. (AD-7; Tr. 23).

The ALJ obviously evaluated Dr. Williams' opinion against the backdrop of his own doubts about the medical validity of a fibromyalgia diagnosis. In the middle of his discussion of Dr. Williams' opinion, the ALJ launched into a long discourse on fibromyalgia. His comments include assertions that "a great deal of controversy has swirled around the issue of categorizing fibromyalgia as a major disorder" (AD-6; Tr. 22) and that "the Social Security disability framework is ill equipped to deal with emerging medical conditions that the medical community has been unable to fully explain" (AD-5; Tr. 21). He went so far as to claim as fact—without citing to any authority or evidence—that "it is rare to find an individual disabled by reason of fibromyalgia." (AD-6; Tr. 22).

Fibromyalgia is a degenerative disorder involving fibrous tissues, muscles, tendons, ligaments, and other connective tissues. *The Merck Manual* 1369-70 (16th ed. 1992). It causes chronic musculoskeletal and muscular pain, joint pain, aching, stiffness, and fatigue, often secondary to sleep disturbance. *Lisa v. Secretary of Dep't of Health & Human Servs.,* 940 F.2d 40, 43-44 (2d Cir. 1991); *Preston v. Secretary of Health and Human Services,* 854 F.2d 815, 818 (6th Cir. 1988) (per curiam). Fibromyalgia can be disabling. *See Kelley v. Callahan,* 133 F.3d 583 (8th Cir. 1998); *Cline v. Sullivan,* 939 F.2d 560, 567 (8th Cir. 1991); *Preston,* 854 F.2d at 818; *Smith v. Schweiker,* 728 F.2d 1158, 1161 (8th Cir. 1984). The onset of pain is sudden, often following an accident, and the disorder "tends to be very persistent and disabling in the sense that the patients assume the role of an invalid." McQuade, J. Stanley, *Medical Information System for Lawyers 2d* 5-43 (2d ed. 1993).

The musculoskeletal pain from fibromyalgia affects a person's ability to sit, stand, lift, etc. In addition, as the Eighth Circuit recognized in *Cline,* "[f]ibromyalgia often leads to a distinct sleep derangement which contributes to a general cycle of daytime fatigue and pain." 939 F.2d at 563.

The presence of fibromyalgia cannot be discounted simply based on the absence of clinical test results. Several circuits have recognized that this disease is not readily detected by standard clinical tests. In *Preston* the Sixth Circuit explained that

> [i]n stark contrast to the unremitting pain of which fibrositis patients complain, physical examinations will usually yield normal results—a full range of motion, no joint swelling, as well as normal muscle strength and neurological reactions. There are no objective tests which can conclusively confirm the disease; rather it is a process of diagnosis by exclusion and testing of certain "focal tender points" on the body for acute tenderness which is characteristic in fibrositis patients.

Id. at 817-18. *See id.* at 819 ("Unlike most diseases that can be confirmed or diagnosed by objective medical tests, fibrositis can only be diagnosed by elimination of other medical conditions which may manifest fibrositis-like symptoms of musculoskeletal pain, stiffness, and fatigue."); *Lisa v. Secretary of Dep't of Health and Human Servs.,* 940 F.2d 40, 43-44 (2d Cir. 1991) (describing fibromyalgia as a disease "that eludes easy diagnosis" and noting that "[t]he Secretary concedes that 'fibrositis, or fibromyalgia, is not easily detected by standard clinical tests'"). In *Sarchet v. Chater,* 78 F.3d 305 (7th Cir. 1996), Judge Posner had these enlightening comments about fibromyalgia:

> Its cause or causes are unknown, there is no cure, and, of greatest importance to disability law, its symptoms are entirely subjective. There are no laboratory tests for the presence or severity of fibromyalgia. The principal symptoms are "pain all over," fatigue, disturbed sleep, stiffness, and—the only symptom that discriminates between it and other diseases of a rheumatic character—multiple tender spots, more precisely 18 fixed locations on the body (and the rule of thumb is that the patient must have at least 11 of them to be diagnosed as having fibromyalgia) that when pressed firmly cause the patient to flinch.

Id. at 306-07. As explained by Judge Posner, there is no definitive laboratory test for fibromyalgia; rather, it is diagnosed by excluding other possible disorders and confirming certain "trigger points." The lack of test results showing an organic cause is typical and consistent with the disease. Fibromyalgia patients, for example, typically manifest normal neurological reactions and have a full ranges of motion. *Preston,* 854 F.2d at 819-20.

This description is fully supported by the medical literature. Dr. Sammaritano's article states that "[d]espite the broad range of symptoms that patients may experience, the physical exam—except for tender points or other allodynia—is generally remarkably normal. (Allodynia is the term for the symptom when ordinarily non-painful stimuli evoke pain.)." Sammaritano, *Fibromyalgia Syndrome.* Regarding negative laboratory tests, Dr. Sammaritano points out that

> [l]aboratory findings in fibromyalgia are classically normal, and routine laboratory tests are not helpful in diagnosing or following FMS. Complete blood count, chemistries (including CPK and aldolase), thyroid function tests, urinalysis, and erythrocyte sedimentation rate are normal in FMS, but they are reasonable screening tests to exclude other disorders. No serologic marker has been identified. Antinuclear antibody (ANA) and rheumatoid factor (RF) tests are typically negative.

Id. Accordingly, negative test results or the absence of an objective medical test to diagnose the condition cannot support a conclusion that a claimant does not suffer from a potentially disabling condition. Because there are no objective clinical or laboratory tests to support a diagnosis of fibromyalgia, their absence is no more indicative that Hatcher's fibromyalgia is not disabling than the absence of headache is an indication that a person's prostate cancer is not advanced.

The ALJ erred by discounting Dr. Williams' opinion on the ground that it is inconsistent with the clinical and laboratory findings in this case. (AD-5; Tr. 21). It is the ALJ's opinion—not the opinion of Dr. Williams—that is conclusory on this point. The ALJ fails to identify precisely *what* clinical and laboratory findings are inconsistent with Dr. Williams' opinion. Repeated examinations by Dr. Williams, Dr. Leaird, and other doctors revealed multiple tender points and Hatcher frequently received trigger point injections. Dr. Sammaritano summarizes the classic symptomology of fibromyalgia:

> Typical tender points in defined anatomic locations . . . are expected. Associated clinical symptoms are diverse and include fatigue, stiffness, paresthesia, skin tenderness, post-exertional pain, lightheadedness, fluid retention, and insomnia. Stress or anxiety, lack of sleep, or cold exposure may exacerbate symptoms. Cognitive complaints (particularly memory and vocabulary problems) are frequent and have been documented with formal testing in several studies.

Sammaritano, *Fibromyalgia Syndrome*. This Court likewise has emphasized that the presence of these tender points is sufficient objective evidence of fibromyalgia. *See Kelley v. Callahan*, 133 F.3d 583, 589 (8th Cir. 1998) (concluding that claimant's

treating physicians' diagnoses of fibromyalgia were "amply supported by clinical data" when based on the presence of trigger points). Dr. Williams' diagnosis is supported by the findings and diagnoses of other doctors, such as Dr. Leaird, Hatcher's treating rheumatologist. Dr. Leaird diagnosed Hatcher as suffering from fibromyalgia in August 1998, has repeated that diagnosis on numerous occasions, and consistently has treated Hatcher for it with prescription medications and trigger point injections. Dr. Valentine, the pain specialist who began treating Hatcher in March 2000, also diagnosed Hatcher with fibromyalgia.

There is no medical evidence in the record from any treating doctor that is inconsistent with the opinions of Dr. Williams. In fact, the *only* medical evidence that supports the ALJ's decision is the opinion of Dr. Leonard, the one-time examining physician consultant who frequently works for the Social Security Administration evaluating disability claims. (see AD-8; Tr. 24). Dr. Leonard found that Hatcher "has classic fibromyalgia" but surprisingly concluded that she has no physical or mental impairments. (Tr. 318). He submitted a form entitled, "Medical Assessment of Ability to Do Work-Related Activities (Physical)," on which he repeatedly indicated that the basis of his findings regarding Hatcher's work-related limitations was a "normal exam." (Tr. 320-23). But, as Dr. Sammaritano states, that "[d]espite the broad range of symptoms that [fibromyalgia] patients may experience, the physical exam—except for tender points or other allodynia—is generally remarkably normal." Sammaritano, *Fibromyalgia Syndrome*.

The ALJ obviously relied on Dr. Leonard's opinion to discredit the opinion of Dr. Williams. (AD-8; Tr. 24). In this instance, the opinion of Dr. Leonard does not constitute substantial evidence upon which to discredit Dr. Williams. This Court's recent decision in *Sandra Cox v. Jo Anne B. Barnhart, Commissioner,* — F.3d — (8th Cir. Oct. 8, 2003) (No. 02-4102), is instructive regarding the weight that the ALJ should have given Dr. Leonard's opinion:

> We have stated many times that the results of a one-time medical evaluation do not constitute substantial evidence on which the ALJ can permissibly base his decisions. *See, e.g., Jenkins v. Apfel,* 196 F.3d 922, 925 (8th Cir. 1999) (stating that the opinion of a consultative physician does not generally satisfy the substantial evidence requirement). This is especially true when the consultative physician is the only examining doctor to contradict the treating physician. *Id.*

— F.3d at — (slip op. at 6). *See Lauer v. Apfel,* 245 F.3d 700, 705 (8th Cir. 2001) ("Generally, even if a consulting physician examines a claimant once, his or her opinion is not considered substantial evidence, especially if . . . the treating physician contradicts the consulting physician's opinion"); *Nevland v. Apfel,* 204 F.3d 853, 858 (8th Cir. 2000) ("[t]he opinions of doctors who have not examined the claimant ordinarily do not constitute substantial evidence on the record as a whole"); *Kelley v. Callahan,* 133 F.3d 583, 589 (8th Cir. 1998) ("[t]he opinion of a consulting physician who examines a claimant once or not at all does not generally constitute substantial evidence").

2. The ALJ improperly discounted Hatcher's subjective complaints.

Hatcher testified that she is unable to work due to arthritis, chronic fatigue syndrome, bilateral carpal tunnel syndrome, fibromyalgia, and depression. Her fingers are often numb and swell. (Tr. 60). She wears wrist splints on both wrists, and only takes them off when she bathes. (Tr. 60). She also has difficulty staying focused and sometimes has problems comprehending things. (Tr. 64). She testified that she could walk only half a block, stand for two to three minutes, and sit for five to six minutes. (Tr. 57). She cannot bend, stoop, or kneel. (Tr. 62). She can carry a gallon of milk only if she braces it against her chest. (Tr. 59). During an average day, Hatcher spends about five hours in bed. Although she listens to the radio and watches television, she cannot stay focused long enough to read. (Tr. 63). She has difficulty sleeping and often has to get up to put on an ice pack. (Tr. 63).

When the ALJ incorporated these limitations into his first hypothetical for the VE, the VE responded that such a person would not be able to return to Hatcher's past work or perform any other work in the national economy. (Tr. 75). Therefore, if the ALJ had believed Hatcher, he would have found her to be disabled. The ALJ instead found that Hatcher's complaints are not credible because they are inconsistent with the medical evidence and other evidence in the record. (AD-14; Tr. 30).

When making determinations regarding the credibility of a claimant's subjective allegations of pain or discomfort, *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir.

1984), requires the administrative factfinder to examine, in addition to the medical evidence, such matters as: (1) the claimant's daily activities, (2) the duration, frequency and intensity of the pain, (3) dosage, effectiveness, and side effects of medication, (4) precipitating and aggravating factors, and (5) functional restrictions. An ALJ may not disregard a claimant's subjective allegations of pain solely because they are not fully supported by the objective medical evidence. *Chamberlain v. Shalala*, 47 F.3d 1489, 1494 (8th Cir. 1995). "'Subjective complaints may be discounted if there are inconsistencies in the evidence as a whole,' and the ALJ [may] properly rel[y] upon discrepancies between [a claimant's] allegations of pain and her treatment history, medicinal selections, and daily activities in disregarding her subjective complaints." *Davis v. Apfel,* 239 F.3d 962, 968 (8th Cir. 2001) (quoting *Polaski,* 739 F.2d at 1322).

The record evidence does not demonstrate any significant inconsistencies between Hatcher's subjective complaints and the medical evidence or her daily activities, treatment history, and medications. As discussed above, the medical evidence supports Hatcher's complaints of chronic pain and limitation from fibromyalgia, including the opinion of her long-time treating doctor that she suffers from "severe" fibromyalgia and is unable to work. Additional medical evidence shows that Hatcher suffers from other medical conditions that contribute to and exacerbate her chronic pain. A November 2000 discogram revealed posterolateral tears at L4-L5 and L5-1 which caused intense concordant pain at rather low pressures. Dr. Valentine diagnosed lumbar annular tear/internal disc disruption

and believed that Hatcher would be a good candidate for intradiscal electrothermal anuloplasty at both levels. (Tr. 468). In April 2000 Dr. Valentine noted that a CT scan revealed osteophyte formation in the lower thoracic spine along with a lumbar MRI revealing degenerative disease with disc bulge in the lower regions. A March 2000 chest x-ray revealed degenerative changes of the lumbar spine with intervertebral spine, narrowing, and vacuum disc phenomena. An osteophyte was also seen over the adjacent thoracic vertebral bodies. (Tr. 354). A CT scan performed in February 2000 revealed a right para-central disc protrusion at L5, and a diffuse bulge at L4 disc. (Tr. 364). This Court has stated that "diagnoses of bulging discs . . . are objective proof of impairments that could account for [the claimant's] pain." *Beckley v. Apfel*, 152 F.3d 1056, 1060 (8th Cir. 1998). Dr. Crawford stated in January 2000 that Hatcher suffers from TMJ and that she would experience some TMJ symptoms with accompanying chronic discomfort for the rest of her life. (Tr. 313). Hatcher also has chronic problems with her knee.

Hatcher's daily activities are extremely limited. She is no longer able to do her housework, and only takes a shower when her husband is home in case she falls. (Tr. 61). Her husband does the laundry, and loads and unloads the dishes. She goes with him sometimes when he does the shopping. (Tr. 62). Hobbies used to include horseback riding, swimming, riding a motorcycle, and boating. (Tr. 61-62). She has not been able to do any of these things since 1997. (Tr. 62). She is not involved in any churches, clubs, or organizations. She only drives to go to doctor appointments when her husband is at work. (Tr. 69). Indeed, the ALJ specifically

acknowledged that "Ms. Hatcher's activities of daily living do not constitute substantial evidence that she has the functional capacity to engage in substantial gainful activity." (Tr. 19).

Hatcher's treatment history is well documented above. She has seen numerous doctors for her complaints, has undergone several tests, has been given multiple trigger point injections, and has been prescribed potent pain medications. She consistently has been prescribed medications for moderate to severe pain, such as Vicodin and Lorcet. She also has been given strong anti-depressant and anti-anxiety medications (Paxil, Pamelor, Celexa, Xanax). *See Beckley*, 152 F.3d at 1060 (refusing to adopt the ALJ's finding of a lack of aggressive treatment in view of claimant's many visits to doctors, variety of treatments for pain, and several diagnostic tests). Hatcher's treatment history and medications clearly support her credibility.

The ALJ's hypothetical to the VE failed to incorporate the degree, effects, and limitations caused by Hatcher's pain. When the claimant's complaints of chronic pain are supported by the medical records, an ALJ's omission of pain-related complaints from the hypothetical question is error. *Ramez v. Shalala,* 26 F.3d 58 (8th Cir. 1994).

CONCLUSION

For the reasons set forth above, the Commissioner's decision that Sharon Hatcher is not disabled is not supported by substantial evidence. The final decision of the Commissioner should be reversed and appropriate benefits awarded or, in the alternative, the case should be remanded for proper evaluation of Hatcher's claim.

Respectfully submitted,

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**CERTIFICATE OF COMPLIANCE WITH FRAP 32(a)(7)
AND EIGHTH CIR. R. 28A(c)**

The undersigned hereby certifies that this brief complies with Federal Rule of Appellate Procedure 32(a)(7) regarding type and volume limitations. The word count is 10,018. The word processing software used is Microsoft Word X for the Macintosh. A copy of the brief has been provided to the Court and Appellee's counsel on CDs. The brief has been converted to Adobe PDF format. The CDs have been scanned for viruses and are virus free.

_____
E. Gregory Wallace

November 17, 2003

CERTIFICATE OF SERVICE

I, E. Gregory Wallace, do hereby certify that I have served a copy of the above and foregoing document on the defendant by mailing a copy of the same to the Thomas Strafuss, Office of the General Counsel, Social Security Administration, 1301 Young Street, Suite 430, Dallas, Texas 75202, on this 18th day of November 2003.

_____

E. Gregory Wallace

ADDENDUM

INDEX TO ADDENDUM